PROPOSED RULE MAKING

CR-102 (June 2004)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Department of Social and Health Services, Health and Recovery Services Administration

☒ **Preproposal Statement of Inquiry was filed as WSR 05-17-140; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR**
☐ **Continuance of WSR**

Title of rule and other identifying information: (Describe Subject)

Sections in Title 388 WAC regarding covered and noncovered services – Part 3 of 3

See "Attachment" for a list of the affected WAC sections.

Hearing location(s):

Blake Office Park East – Rose Room
4500 – 10th Ave. SE
Lacey, Washington 98503
(One block north of the intersection of Pacific Ave. SE and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling 360-664-6097)

Date: **November 7, 2006** Time: **10:00 a.m.**

Submit written comments to:

Name: DSHS Rules Coordinator
Address: PO Box 45850, Olympia WA, 98504
Delivery: 4500 – 10th Ave. SE, Lacey, Washington 98503
E-mail: fernaax@dshs.wa.gov Fax: (360) 664-6185
by **5:00 p.m. on November 7, 2006**

Date of intended adoption: Not earlier than November 8, 2006 (Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Stephanie Schiller, DSHS Rules Consultant by November 3, 2006
TTY (360) 664-6178 or (360) 664-6097 or
by e-mail at schilse@dshs.wa.gov

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

See "Attachment" for purpose and explanation of changes.

Reasons supporting proposal: It will make HRSA's rules regarding covered and noncovered medical services clearer and easier to understand for our clients and medical providers.

Statutory authority for adoption:
RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700

Statute being implemented:
RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE 9/15/06

NAME (type or print) Andy Fernando

SIGNATURE

TITLE Manager, Rules and Policies Assistance Unit

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

SEP 19 2006

TIME 4:05 AM PM
WSR 06-19-100

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
None.

Name of proponent: (person or organization) Department of Social and Health Services

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Kevin Sullivan	626-8th Ave, Olympia, WA 98504-5504	(360) 725-1344
Implementation....	Gail Kreiger	" " "	(360) 725-1681
Enforcement.....	"	" " "	(360) 725-1681

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

☐ Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( )
fax ( )
e-mail

☒ No. Explain why no statement was prepared.

This amendment does not create more than minor costs to small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name: Kevin Sullivan, HRSA Rules Coordinator
Address: P.O. Box 45504, Olympia, WA 98504-4405
Phone: (360) 725-1344 Fax: (360) 586-9727
E-mail: sullikm@dshs.wa.gov TYY/TDD: 1-800-848-5429

☐ No: Please explain:

Attachment to CR-102 (Part 3 of 3)
For Preproposal Statement of Inquiry filed as WSR 05-17-140

WAC Sections Proposed in Part 3:

WAC 388-543-1100, Scope of Coverage and Limitations for DME
WAC 388-543-1150, Limits and Limitation Extensions
WAC 388-543-1300, Equipment, Related Supplies, or other Nonmedical Supplies, and Devices Not Covered
WAC 388-544-0010, Vision Care – General
WAC 388-544-0450, Vision Care – Prior Authorization
WAC 388-544-1100, Hearing Aid Services – General
WAC 388-544-1400, Hearing Aid Services – Noncovered Services
WAC 388-545-900, Neurodevelopmental Centers
WAC 388-546-0200, Scope of Coverage for Ambulance Transportation
WAC 388-546-0250, Ambulance Services the Department Does Not Cover
WAC 388-550-2596, Services and Equipment Covered by the Department but Not Included in LTAC Fixed Per Diem Rate
WAC 388-551-2130, Noncovered Home Health Services
WAC 388-551-3000, Private Duty Nursing Services for Clients Seventeen and Younger
WAC 388-553-500, Home Infusion Therapy/Parenteral Nutrition Program – Coverage
WAC 388-554-500, Orally Administered Enteral Nutrition Products – Coverage
WAC 388-554-600, Tube-Delivered Enteral Nutrition Products and Related Equipment and Supplies – Coverage
WAC 388-556-0500, Medical Care Services Under State-Administered Cash Programs
WAC 388-800-0045, What Services are Offered by ADATSA?

Purpose of Rule Amendment

The purpose of the proposal is to:

- Improve the quality of care received by DSHS clients by using a consistent, evidence-based approach to making benefit coverage decisions.
- Make HRSA benefit coverage rules clearer, more transparent, and consistent.
- Establish a clear, transparent process by which HRSA determines what services are included under its benefit coverage.
- Maximize program resources through prudent use of cost-effective practices.

Changes to Rule in Parts 1, 2, and 3

In this proposal, the department has:

- Replaced "Medical Assistance Administration" and "MAA" with "the department" or "HRSA."
- Substituted WAC 388-501-0160 cross reference in place of WAC 388-501-0165 where noncovered services are addressed.
- Replaced all references to chapter 388-529 WAC with new WAC 388-501-0060 and WAC 388-501-0065.
- Added reference to new WAC 388-501-0169 in rules where limitations on covered services are addressed.
- Repealed chapter 388-529 WAC which is being replaced with WAC 388-501-0060 and WAC 388-501-0065.

Attachment to CR-102 (Part 3 of 3)
For Preproposal Statement of Inquiry filed as WSR 05-17-140

- Repealed WAC 388-501-0300 because it was incorporated into WAC 388-501-0050 and WAC 388-501-0070.
- Removed gender reassignment surgery from covered service status.
- More clearly defined what is covered and not covered in the way of cosmetic and reconstructive surgery, treatment, and procedures in WAC 388-531-0100 and new WAC 388-501-0070.
- Added more detail to WAC 388-501-0160 regarding the criteria and steps in the exception to rule (ETR) process.
- In new WAC 388-501-0065, added brief descriptions of services available under each category of service listed in the table in new WAC 388-501-0060.
- Included cross references (in new WAC 388-501-0065 and WAC 388-501-0070) to other program WACs where the reader can find more specific detail of the covered or noncovered service.
- Codified the evaluation criteria HRSA will use when evaluating requests for covered services beyond the maximum allowed.

AMENDATORY SECTION (Amending WSR 05-21-102, filed 10/18/05, effective 11/18/05)

WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services. The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics**, **orthotics**, and **medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment **(EPSDT)** program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The ((~~medical assistance administration (MAA)~~)) department covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when they are:

(a) Within the scope of an eligible client's medical care program (see ((~~chapter 388-529~~)) WAC 388-501-0060 and WAC 388-501-0065);

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC). Except for dual eligible Medicare/Medicaid clients, the prescription must:

(i) Be dated and signed by the prescriber;

(ii) Be less than six months in duration from the date the prescriber signs the prescription; and

(iii) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity;

(e) Billed to the department as the payor of last resort only. ((~~MAA~~)) The department does not pay first and then collect from Medicare and;

(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

(i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, ARNP, PAC, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; and/or

(ii) Video and/or photograph(s) of the client demonstrating the impairments as well and client's ability to use the requested equipment, when applicable.

(2) ((~~MAA~~)) The department evaluates a request for any equipment or device((~~s that are~~)) listed as noncovered in WAC 388-543-1300 under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

(3) ((~~MAA~~)) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165 ((~~which relate to medical necessity~~)).

(4) ((~~MAA~~)) The department evaluates requests for covered services in this chapter that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions ((~~when medically necessary, under the standards for covered services in~~)) under the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(5) ((~~MAA~~)) The department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both **Medicare** and Medicaid, and is staying in a **nursing facility** in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(6) ((~~MAA~~)) The department covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in ((~~MAA's~~)) the department's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.

(7) An interested party may request ((~~MAA~~)) the department to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (including FDA approval, if required); and

(d) Any additional information the requester feels is important.

(8) ((~~MAA~~)) The department bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

(9) ((~~MAA~~)) The department covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.

(10) ((~~MAA~~)) The department covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician, ARNP, or PAC, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;

(c) Prosthetic/orthotic devices;

(d) Surgical/ostomy appliances and urological supplies;
(e) Bandages, dressings, and tapes;
(f) Equipment and supplies for the management of diabetes; and
(g) Other medical equipment and supplies((~~, as~~)) listed in ((~~MAA~~)) department published issuances.

(11) ((~~MAA~~)) The department evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

(12) For a client in a **nursing facility,** ((~~MAA~~)) the department covers only the following when medically necessary. All other DME and supplies identified in ((~~MAA~~)) the department's billing instructions are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4). ((~~MAA~~)) The department covers:

(a) The purchase and repair of a speech generating device (SGD), a wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate, or a **specialty bed;** and

(b) The rental of a speciality bed.

(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.

(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice.

AMENDATORY SECTION (Amending WSR 05-21-102, filed 10/18/05, effective 11/18/05)

WAC 388-543-1150 Limits and limitation extensions. The ((~~medical assistance administration (MAA)~~)) department covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). ((~~MAA~~)) The department limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client. In order to exceed the stated limits, the provider must request a limitation extension (LE), which is a form of prior authorization (PA). ((~~MAA approves~~)) The department evaluates such requests for LE ((~~when medical necessary,~~)) under the ((~~standards for covered services in WAC 388-501-0165~~)) provisions of WAC 388-501-0169. Procedures for LE are found in ((~~MAA's~~)) department billing instructions. The following items and quantities do not require prior authorization; requests to exceed the stated quantities require LE:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one pint per

month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month;

(e) Disinfectant spray - one twelve-ounce bottle or can per six-month period; or

(f) Periwash (when soap and water are medically contraindicated) - one five-ounce bottle of concentrate solution per six-month period.

(2) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three-month period; and

(b) Spring-powered device for lancet - one in a six-month period.

(3) Braces, belts and supportive devices:

(a) Custom vascular supports (CVS) - two pair per six-month period. CVS fitting fee - two per six-month period;

(b) Surgical stockings (below-the-knee, above-the-knee, thigh-high, or full-length) - two pair per six-month period;

(c) Graduated compression stockings for pregnancy support (pantyhose style) - two per twelve-month period;

(d) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(e) Ankle, elbow, or wrist brace - two per twelve-month period;

(f) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(g) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended

wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. ((~~MAA~~)) The department does not allow the following to be used on a faceplate in combination with drainable pouches (refer to the billing instructions for further details):

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(6) Supplies associated with client-owned transcutaneous electrical nerve stimulators (TENS):

(a) For a four-lead TENS unit - two kits per month. (A kit contains two leads, conductive paste or gel, adhesive, adhesive remover, skin preparation material, batteries, and a battery charger for rechargeable batteries.)

(b) For a two-lead TENS unit - one kit per month.

(c) TENS tape patches (for use with carbon rubber electrodes only) are allowed when they are not used in combination with a kit(s).

(d) A TENS stand alone replacement battery charger is allowed when it is not used in combination with a kit(s).

(7) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half

inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a backsheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a topsheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the backsheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a backsheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be

contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) ((~~MAA~~)) The department covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. ((~~MAA~~)) The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see ((~~MAA's~~)) department billing instructions for how to specify this when billing). The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit (see subsections (g), (h), (i), (j), (k), (l), and (m) of this section for product limitations). The following products cannot be used together:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Three hundred per month for a child three to eighteen years of age; and

(ii) Two hundred forty per month for an adult nineteen years of age and older.

(h) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred forty per month.

(i) Disposable briefs and pull-up pants (any size) are limited to:

(i) Three hundred per month for a child age three to eighteen years of age; and

(ii) One hundred fifty per month for an adult nineteen years of age and older.

(j) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(k) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred forty per month.

(l) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(8) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without

anti-reflux device, with or without tube - two per month. This cannot be billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. This cannot be billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. These cannot be billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. These cannot be billed in combination with: Other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. These cannot be billed in combination with: An insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston) - cannot be billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. These cannot be billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. These cannot be billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric). Allowed as replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. This cannot be billed in combination with: a latex urinary leg bag; urinary suspensory without leg bag; extension drainage tubing; or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. This cannot be billed in combination with: A leg strap; or an insertion tray with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. This cannot be billed in combination with an insertion tray with drainage bag and with or without catheter.

(9) Miscellaneous supplies:

(a) Bilirubin light therapy supplies - five days' supply. ((~~MAA~~)) The department reimburses only when these are provided with

a prior authorized bilirubin light.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Lice comb (e.g., LiceOut TM, or LiesMeister TM, or combs of equivalent quality and effectiveness) - one per year.

(f) Nontoxic gel (e.g., LiceOut TM) for use with lice combs - one bottle per twelve month period.

(g) Syringes and needles ("sharps") disposal container for home use, up to one gallon size - two per month.

(10) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period.

(b) Blood glucose monitor (specialized or home) - one in a three-year period.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Diaphragmatic pacing antennae - four per twelve month-period.

(e) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(f) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap w/adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(11) Prosthetics and orthotics:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(12) Positioning devices:

(a) Deluxe floor sitter/feeder seat (small, medium, or large), including floor sitter wedge, shoulder harness, and hip strap - one in a three-year period.

(b) High-back activity chair, including adjustable footrest, two pairs of support blocks, and hip strap - one in a three-year period.

(c) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(d) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(e) Adjustable standing frame (for child/adult thirty - sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor,

and a pair of foot blocks - one in a five-year period.

AMENDATORY SECTION (Amending WSR 02-16-054, filed 8/1/02, effective 9/1/02)

WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. (1) ((~~MAA~~)) The department pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered in this chapter, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200.

(2) ((~~MAA~~)) The department pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and 388-543-1200.

(3) ((~~MAA~~)) The department considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services ((~~and noncovered equipment, related supplies and services, supplies and devices,~~)) under the provisions of WAC 388-501-0165. ((~~When MAA considers that a request does not meet the requirement for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.~~))

(4) ((~~MAA~~)) The department evaluates a request for any DME item listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(5) The department specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

(a) Included as part of a managed care plan service package;

(b) Included in a waivered program;

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries; or

(d) Requested for a child who is eligible for services under the EPSDT program. ((~~MAA~~)) The department reviews these requests according to the provisions of chapter 388-534 WAC.

((~~(5)~~)) (6) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the ((~~department of the~~)) Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS)((~~, formerly known as the Health Care Financing Administration (HCFA)~~)) consider investigative or experimental on the date the services are provided;

(b) Any service specifically excluded by statute;

(c) A client's utility bills, even if the operation or

maintenance of medical equipment purchased or rented by ((~~MAA~~)) the department for the client contributes to an increased utility bill (refer to the aging and ((~~adult~~)) disability services administration's ((~~(AASA)~~)) (ADSA) COPES program for potential coverage);

(d) Hairpieces or wigs;

(e) Material or services covered under manufacturers' warranties;

(f) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(g) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(h) Prosthetic devices dispensed solely for cosmetic reasons (refer to WAC 388-531-0150 (1)(d));

(i) Home improvements and structural modifications, including but not limited to the following:

(i) Automatic door openers for the house or garage;

(ii) Saunas;

(iii) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(iv) Swimming pools;

(v) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(vi) Electrical rewiring for any reason;

(vii) Elevator systems and elevators; and

(viii) Lifts or ramps for the home; or

(ix) Installation of bathtubs or shower stalls.

(j) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(i) Back-packs, pouches, bags, baskets, or other carrying containers;

(ii) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(iii) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(iv) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(v) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(vi) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(A) Devices intended for amplifying voices (e.g., microphones);

(B) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to ((~~AASA~~)) ADSA COPES or outpatient hospital programs for emergency response systems and services);

(C) Two-way radios; and

(D) Rental of related equipment or services;

(vii) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;

(viii) Ergonomic equipment;

(ix) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(x) Generators;

(xi) Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(xii) Computer utility bills, telephone bills, internet service, or technical support for computers or electronic notebooks;

(xiii) Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);

(xiv) Racing strollers/wheelchairs and purely recreational equipment;

(xv) Room fresheners/deodorizers;

(xvi) Bidet or hygiene systems, paraffin bath units, and shampoo rings;

(xvii) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(xviii) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(xix) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(k) Personal and **comfort items** that do not meet the DME definition, including but not limited to the following:

(i) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(ii) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers and sheets;

(iii) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(iv) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;

(v) Clothing protectors and other protective cloth furniture coverings;

(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves for bathtub;

(viii) Eating/feeding utensils;

(ix) Emesis basins, enema bags, and diaper wipes;

(x) Health club memberships;

(xi) Hot or cold temperature food and drink containers/holders;

(xii) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(xiii) Impotence devices;

(xiv) Insect repellants;

(xv) Massage equipment;

(xvi) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(xvii) Medicine cabinet and first-aid items, such as adhesive

bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(xviii) Page turners;

(xix) Radio and television;

(xx) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(xxi) Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

(l) Certain wheelchair features and options are not considered by ((~~MAA~~)) the department to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(i) Attendant controls (remote control devices);

(ii) Canopies, including those for strollers and other equipment;

(iii) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(iv) Identification devices (such as labels, license plates, name plates);

(v) Lighting systems;

(vi) Speed conversion kits; and

(vii) Tie-down restraints, except where medically necessary for client-owned vehicles.

AMENDATORY SECTION (Amending WSR 05-13-038, filed 6/6/05, effective 7/7/05)

WAC 388-544-0010 Vision care--General. (1) The ((~~medical assistance administration (MAA)~~)) department covers ((~~the~~)) vision care ((~~listed in this chapter only,~~)) services subject to the exceptions, restrictions, and limitations listed in this chapter. Vision care is covered when ((~~they are~~)) it is:

(a) Within the scope of the eligible client's medical care program (see ((~~chapter 388-529~~)) WAC 388-501-0060 and WAC 388-501-0065); and

(b) Medically necessary as defined in WAC 388-500-0005.

(2) ((~~MAA~~)) The department evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(3) ((~~MAA~~)) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions ((~~when medically necessary,~~)) under the ((~~standards for covered services in WAC 388-501-0165~~)) provisions of WAC 388-501-0169.

(4) ((~~MAA~~)) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165.

AMENDATORY SECTION (Amending WSR 05-13-038, filed 6/6/05, effective 7/7/05)

WAC 388-544-0450 Vision care--Prior authorization. (1) The ((~~medical assistance administration (MAA)~~)) department requires a provider to follow the prior authorization and expedited prior authorization (EPA) process for certain vision care services as identified in this chapter.

(2) For prior authorization (PA), a provider must call or send the department a fax ((~~MAA~~)) using the appropriate telephone or fax number listed in ((~~MAA's~~)) the department's published vision care billing instructions.

(3) For expedited prior authorization (EPA), a provider must create an EPA number. The process and criteria used to create this authorization number are explained in ((~~MAA's~~)) the department's published vision care billing instructions. The EPA number must be used when the provider bills ((~~MAA~~)) the department.

(4) ((~~MAA~~)) The department denies payment for vision care submitted without the required PA or EPA number, or the appropriate diagnosis or procedure code as indicated by the EPA number.

(5) Upon request, a provider must provide documentation to ((~~MAA~~)) the department showing how the client's condition met the criteria for PA or EPA.

(6) ((~~MAA~~)) The department may recoup any payment made to a provider under this chapter if ((~~MAA~~)) the department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100 (1)(c).

(7) When a client's situation does not meet the EPA criteria for vision care, or a requested service or item exceeds the limit indicated in this chapter, a provider must follow the requirements of WAC 388-501-0165 and WAC 388-501-0169.

(8) ((~~MAA~~)) The department evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 00-23-068, filed 11/15/00, effective 12/16/00)

WAC 388-544-1100 Hearing aid services--General. (1) ((~~MAA~~)) The department covers only the hearing aid services listed in this chapter, subject to the exceptions, restrictions, and limitations listed in this chapter.

(2) ((~~MAA~~)) The department evaluates requests for covered services ((~~listed as noncovered or~~)) that are subject to limitations or other restrictions ((~~according to the provisions~~)) and approves such services beyond those limitations or restrictions as described in WAC ((~~388-501-0165~~)) 388-501-0169.

(3) ((~~MAA~~)) The department evaluates requests for any service listed as noncovered in this chapter under the provisions in WAC 388-501-0160.

(4) The department reimburses providers at the maximum allowable rates established by ((~~MAA~~)) the department.

AMENDATORY SECTION (Amending WSR 00-23-068, filed 11/15/00, effective 12/16/00)

WAC 388-544-1400 Hearing aid services--Noncovered services. (1) ((~~MAA~~)) The department does not cover any of the following:

(a) The purchase of batteries, ear trumpets, or tinnitus maskers;

(b) Group screenings for hearing loss, except as provided under the Healthy Kids/EPSDT program under WAC 388-534-0100;

(c) Computer-aided hearing devices used in school;

(d) Hearing aid charges reimbursed by insurance or other payer source;

(e) Digital hearing aids; or

(f) FM systems or programmable hearing aids for:

(i) Adults;

(ii) Children when the device is used in school; or

(iii) Children whose hearing loss is adequately improved with hearing aids.

(2) ((~~MAA~~)) The department evaluates a request for any service listed in this section ((~~according to~~)) as noncovered under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

AMENDATORY SECTION (Amending WSR 01-20-114, filed 10/3/01, effective 11/3/01)

WAC 388-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed ((~~as such~~)) by the ((~~medical assistance administration (MAA)~~)) department;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, ((~~MAA~~)) the department requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to ((~~MAA~~)) the department;

(c) Sign a core provider agreement with ((~~MAA~~)) the department; and

(d) Receive a neurodevelopmental center provider number from ((~~MAA~~)) the department.

(3) Clients who are twenty years of age or younger and who

meet the following eligibility criteria may receive covered services from neurodevelopmental centers:

(a) For occupational therapy, refer to WAC 388-545-300(2);

(b) For physical therapy, refer to WAC 388-545-500(2);

(c) For speech therapy and audiology services, refer to WAC 388-545-700(2); and

(d) For early and periodic screening, diagnosis and treatment (EPSDT) screening by physicians, refer to WAC ((~~388-529-0200~~)) 388-534-0100.

(4) ((~~MAA~~)) The department reimburses neurodevelopmental centers for providing the following services to clients who meet the requirements in subsection (3) of this section:

(a) Occupational therapy services as described in WAC 388-545-300;

(b) Physical therapy services as described in WAC 388-545-500;

(c) Speech therapy and audiology services as described in WAC 388-545-700; and

(d) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in ((~~MAA's~~)) the department's billing instructions.

(5) In order to be reimbursed, neurodevelopmental centers must meet ((~~MAA's~~)) the department's billing requirements in WAC 388-502-0020, 388-502-0100 and 388-502-0150.

AMENDATORY SECTION (Amending WSR 04-17-118, filed 8/17/04, effective 9/17/04)

WAC 388-546-0200 Scope of coverage for ambulance transportation. (1) The ambulance program is a medical transportation service. The medical assistance administration (MAA) pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see ((~~chapter 388-529 WAC, Scope of medical services~~)) WAC 388-501-0060);

(b) Medically necessary as defined in WAC 388-500-0005 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The nearest appropriate MAA-contracted medical provider of MAA-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) MAA limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ambulance service is not covered by

MAA. See WAC 388-546-0250 (1) and (2) for noncovered ambulance services.

(3) If Medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, MAA requires the provider when billing MAA for that trip to:

(a) Report the third party determination on the claim; and

(b) Submit documentation showing that the trip meets the medical necessity criteria of MAA. See WAC 388-546-1000 and 388-546-1500 for requirements for nonemergency ambulance coverage.

(4) MAA covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when MAA determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the air ambulance transportation must be prior authorized by MAA. See WAC 388-546-1500 for nonemergency air ambulance coverage.

AMENDATORY SECTION (Amending WSR 04-17-118, filed 8/17/04, effective 9/17/04)

WAC 388-546-0250 Ambulance services ((~~that MAA~~)) the department does not cover. (1) The ((~~medical assistance administration (MAA)~~)) department does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 388-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC 388-546-4000(2));

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC 388-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, ((~~MAA~~)) the department does

not cover the ambulance service, except as provided in WAC 388-546-0500(2).

(3) ((~~MAA~~)) The department evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, ((~~MAA~~)) the department evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. ((~~MAA~~)) The department approves such requests when medically necessary, ((~~in accordance with~~)) according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 388-502-0160 are met.

AMENDATORY SECTION (Amending WSR 03-02-056, filed 12/26/02, effective 1/26/03)

WAC 388-550-2596 Services and equipment covered by ((~~MAA~~)) the department but not included in the LTAC fixed per diem rate. (1) ((~~MAA~~)) The department uses the ratio of costs-to-charges (RCC) payment method to reimburse an LTAC facility for the following that are not included in the LTAC fixed per diem rate:

(a) Pharmacy - After the first two hundred dollars per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;

(b) Radiology services;

(c) Nuclear medicine services;

(d) Computerized tomographic (CT) scan;

(e) Operating room services;

(f) Anesthesia services;

(g) Blood storage and processing;

(h) Blood administration;

(i) Other imaging services - Ultrasound;

(j) Pulmonary function services;

(k) Cardiology services;

(l) Recovery room services;

(m) EKG/ECG services;

(n) Gastro-intestinal services;

(o) Inpatient hemodialysis; and

(p) Peripheral vascular laboratory services.

(2) ((~~MAA~~)) The department uses the appropriate inpatient or outpatient payment method described in other published WAC to reimburse providers other than LTAC facilities for services and equipment that are covered by ((~~MAA~~)) the department but not included in the LTAC fixed per diem rate. The provider must bill ((~~MAA~~)) the department directly and ((~~MAA~~)) the department reimburses the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of

outpatient medical services while the client is still an inpatient at the LTAC facility, or related to transporting a client to another facility after discharge from the LTAC facility:

(a) Are not covered or reimbursed through the LTAC fixed per diem rate;

(b) Are not reimbursable directly to the LTAC facility;

(c) Are subject to the provisions in chapter 388-546 WAC; and

(d) Must be billed directly to the:

(i) Department by the transportation company to be reimbursed if the client required ambulance transportation; or

(ii) Department's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 388-546 WAC, if the client:

(A) Required nonemergent transportation; or

(B) Did not have a medical condition that required transportation in a prone or supine position.

(4) ((~~MAA~~)) The department evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions ((~~when medically necessary,~~)) under the ((~~standards~~)) provisions of WAC 388-501-0165 and WAC 388-501-0169.

AMENDATORY SECTION (Amending WSR 02-15-082, filed 7/15/02, effective 8/15/02)

WAC 388-551-2130 Noncovered home health services. (1) ((~~MAA~~)) The Health and Recovery Services Administration (HRSA) does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and ((~~adult~~)) disability services administration ((~~(AASA) or division of developmental disabilities (DDD)~~)) (ADSA).

(i) ((~~MAA~~)) HRSA considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ((~~AASA or DDD~~)) ADSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, ((~~MAA~~)) HRSA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities,

skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) CNP - emergency medical only; and

(ii) LCP-MNP - emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) ((~~MAA~~)) HRSA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

(m) Home health visits made without a written physician's order, unless the verbal order is:

(i) Documented prior to the visit; and

(ii) The document is signed by the physician within forty-five days of the order being given.

(2) ((~~MAA~~)) HRSA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) ((~~MAA~~)) HRSA evaluates a request for any service that is listed as noncovered under the provisions of WAC ((~~388-501-0165~~)) 388-501-0160.

AMENDATORY SECTION (Amending WSR 01-05-040, filed 2/14/01, effective 3/17/01)

WAC 388-551-3000 Private duty nursing services for clients seventeen years of age and younger. This section applies to private duty nursing services for eligible clients on fee-for-service programs. Managed care clients receive private duty nursing services through their plans (see chapter 388-538 WAC).

(1) **"Private duty nursing"** means four hours or more of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services. Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

(a) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity,

hydration, level of consciousness, constant observation for comfort and pain management);

(b) Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bilevel positive airway pressure, intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);

(c) Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO_2s, ventilator settings, humidification systems, fluid balance, etc.); and

(d) Interventions (e.g., medications, suctioning, IV's, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

(2) To be eligible for private duty nursing services, a client must meet all the following:

(a) Be seventeen years of age or younger (see chapter 388-71 WAC for information about private duty nursing services for clients eighteen years of age and older);

(b) Be eligible for categorically needy (CN) or medically needy (MN) scope of care (see WAC ((~~388-529-0100 and 388-529-0200 for client eligibility~~)) 388-501-0060 and WAC 388-501-0065);

(c) Need continuous skilled nursing care that can be provided safely outside an institution; and

(d) Have prior authorization from the department.

(3) The department contracts only with home health agencies licensed by Washington state to provide private duty nursing services and pays a rate established by the department according to current funding levels.

(4) A provider must coordinate with a division of developmental disabilities case manager and request prior authorization by submitting a complete referral to the department, which includes all of the following:

(a) The client's age, medical history, diagnosis, and current prescribed treatment plan, as developed by the individual's physician;

(b) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;

(c) An emergency medical plan which includes notification of electric, gas and telephone companies as well as local fire department;

(d) Psycho-social history/summary which provides the following information:

(i) Family constellation and current situation;

(ii) Available personal support systems;

(iii) Presence of other stresses within and upon the family; and

(iv) Projected number of nursing hours needed in the home, after discussion with the family or guardian.

(e) A written request from the client or the client's legally authorized representative for home care.

(5) The department approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

(a) The information submitted by the provider is complete;

(b) The care provided will be based in the client's home;

(c) Private duty nursing will be provided in the most cost-effective setting;

(d) An adult family member, guardian, or other designated

adult has been trained and is capable of providing the skilled nursing care;

(e) A registered or licensed practical nurse will provide the care under the direction of a physician; and

(f) Based on the referral submitted by the provider, the department determines:

(i) The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;

(ii) The client requires more nursing care than is available through the home health services program; and

(iii) The home care plan is safe for the client.

(6) Upon approval, the department will authorize private duty nursing services up to a maximum of sixteen hours per day except as provided in subsection (7) of this section, restricted to the least costly equally effective amount of care.

(7) The department may authorize additional hours:

(a) For a maximum of thirty days if any of the following apply:

(i) The family or guardian is being trained in care and procedures;

(ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that noninstitutionalized care is still safe for the client;

(iii) The family or guardian caregiver is ill or temporarily unable to provide care;

(iv) There is a family emergency; or

(v) The department determines it is medically necessary.

(b) ((~~If~~)) After the department ((~~determines it is medically necessary~~)) evaluates the request according to the ((~~process explained in~~)) provisions of WAC 388-501-0165((~~, Determination process for coverage of medical equipment and medical or dental services~~)) and WAC 388-501-0169.

(8) The department adjusts the number of authorized hours when the client's condition or situation changes.

(9) Any hours of nursing care in excess of those authorized by the department are the responsibility of the client, family or guardian.

AMENDATORY SECTION (Amending WSR 04-11-007, filed 5/5/04, effective 6/5/04)

WAC 388-553-500 Home infusion therapy/parenteral nutrition program--Coverage, services, limitations, prior authorization, and reimbursement. (1) The home infusion therapy/parenteral nutrition program covers the following for eligible clients, subject to the limitations and restrictions listed:

(a) Home infusion supplies, limited to one month's supply per client, per calendar month.

(b) Parenteral nutrition solutions, limited to one month's supply per client, per calendar month.

(c) One type of infusion pump, one type of parenteral pump, and/or one type of insulin pump per client, per calendar month and as follows:

(i) All rent-to-purchase infusion, parenteral, and/or insulin pumps must be new equipment at the beginning of the rental period.

(ii) ((~~MAA~~)) The department covers the rental payment for each type of infusion, parenteral, or insulin pump for up to twelve months. (((~~MAA~~)) The department considers a pump purchased after twelve months of rental payments.)

(iii) ((~~MAA~~)) The department covers only one purchased infusion pump or parenteral pump per client in a five-year period.

(iv) ((~~MAA~~)) The department covers only one purchased insulin pump per client in a four-year period.

(2) Covered supplies and equipment that are within the described limitations listed in subsection (1) of this section do not require prior authorization for reimbursement.

(3) Requests for supplies and/or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on an individual basis according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(4) ((~~MAA's~~)) Department reimbursement for equipment rentals and purchases includes the following:

(a) Instructions to a client or a caregiver, or both, on the safe and proper use of equipment provided;

(b) Full service warranty;

(c) Delivery and pickup; and

(d) Setup, fitting, and adjustments.

(5) Except as provided in subsection (6) of this section, ((~~MAA~~)) the department does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive ((~~MAA's~~)) the department's hospice benefit, unless both of the following apply:

(i) The client has a preexisting diagnosis that requires parenteral support; and

(ii) The preexisting diagnosis is not related to the diagnosis that qualifies the client for hospice.

(6) ((~~MAA~~)) The department pays separately for a client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies when the client:

(a) Resides in a nursing facility; and

(b) Meets the criteria in WAC 388-553-300.

AMENDATORY SECTION (Amending WSR 05-04-059, filed 1/28/05, effective 3/1/05)

WAC 388-554-500 Orally administered enteral nutrition products--Coverage, limitations, and reimbursement. (1) The

enteral nutrition program covers and reimburses medically necessary orally administered enteral nutrition products, subject to:

(a) Prior authorization requirements under WAC 388-554-700;

(b) Duration periods determined by the ((~~medical assistance administration (MAA)~~)) department;

(c) Delivery requirements under WAC 388-554-400(2); and

(d) The provisions in other applicable WAC.

(2) Except as provided in subsection (3) of this section, ((~~MAA~~)) the department does not pay separately for orally administered enteral nutrition products:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive ((~~MAA's~~)) the department's hospice benefit, unless both of the following apply:

(i) The client has a pre-existing medical condition that requires enteral nutritional support; and

(ii) The pre-existing medical condition is not related to the diagnosis that qualifies the client for hospice.

(3) ((~~MAA~~)) The department pays separately for a client's orally administered enteral nutrition products when the client:

(a) Resides in ((~~the~~)) a nursing facility;

(b) Meets the criteria in WAC 388-554-300; and

(c) Needs enteral nutrition products to meet one hundred percent of the client's nutritional needs.

(4) ((~~MAA~~)) The department does not cover or ((~~reimburse~~)) pay for orally administered enteral nutrition products when the client's nutritional need can be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs.

(5) ((~~MAA~~)) The department:

(a) Determines reimbursement for oral enteral nutrition products according to a set fee schedule;

(b) Considers Medicare's current fee schedule when determining maximum allowable fees;

(c) Considers vendor rate increases or decreases as directed by the Legislature; and

(d) Evaluates and updates the maximum allowable fees for oral enteral nutrition products at least once per year.

(6) ((~~MAA~~)) The department evaluates a request for orally administered enteral nutrition products that are ((~~not covered or are~~)) in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(7) The department evaluates a request for orally administered enteral nutrition products that are listed as noncovered in this chapter according to the provisions of WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 05-04-059, filed 1/28/05,

effective 3/1/05)

WAC 388-554-600 Tube-delivered enteral nutrition products and related equipment and supplies--Coverage, limitations, and reimbursement. (1) The enteral nutrition program covers and reimburses the following, subject to the limitations listed in this section and the provisions in other applicable WAC:

(a) Tube-delivered enteral nutrition products;

(b) Tube-delivery supplies;

(c) Enteral nutrition pump rental and purchase;

(d) Nondisposable intravenous (IV) poles required for enteral nutrition product delivery; and

(e) Repairs to equipment.

(2) The ((~~medical assistance administration (MAA)~~)) department covers up to twelve months of rental payments for enteral nutrition equipment. After twelve months of rental, ((~~MAA~~)) the department considers the equipment ((~~to be~~)) purchased and it becomes the client's property.

(3) ((~~MAA~~)) The department requires a provider to furnish clients new or used equipment that includes full manufacturer and dealer warranties for one year.

(4) ((~~MAA~~)) The department covers only one:

(a) Purchased pump per client in a five year period; and

(b) Purchased nondisposable IV pole per ((~~a~~)) client for that client's lifetime.

(5) ((~~MAA's~~)) The department's reimbursement for covered enteral nutrition equipment and necessary supplies includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or the client's caregiver in the appropriate use of the equipment and necessary supplies.

(6) A provider is responsible for any costs incurred to have another provider repair equipment if all of the following apply:

(a) Any equipment that ((~~MAA~~)) the department considers purchased requires repair during the applicable warranty period;

(b) The provider is unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) If ((~~the~~)) a rental equipment the department considers to have been purchased must be replaced during the warranty period, ((~~MAA~~)) the department recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client. All of the following must apply:

(a) The provider is unable to fulfill the warranty; and

(b) The client still needs the equipment.

(8) ((~~MAA~~)) The department rescinds any authorization for prescribed equipment if the equipment was not delivered to the client before the client:

(a) Loses medical eligibility;

(b) Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related

condition(s);

(c) Becomes eligible for ((~~an MAA~~)) a department-contracted managed care plan; or

(d) Dies.

(9) Except as provided in subsection (10) of this section, ((~~MAA~~)) the department does not pay separately for tube-delivered enteral nutrition products or necessary equipment or supplies when a client:

(a) Resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) Has elected and is eligible to receive ((~~MAA's~~)) the department's hospice benefit, unless both of the following apply:

(i) The client has a pre-existing medical condition that requires enteral nutritional support; and

(ii) The pre-existing medical condition is not related to the diagnosis that qualifies the client for hospice.

(10) ((~~MAA~~)) The department pays separately for a client's tube-delivered enteral nutrition products and necessary equipment and supplies when:

(a) The client resides in ((~~the~~)) a nursing facility;

(b) The client meets the eligibility criteria in WAC 388-554-300; and

(c) Use of enteral nutrition products meets one hundred percent of the client's nutritional needs.

(11) ((~~MAA~~)) The department determines reimbursement for tube-delivered enteral nutrition products and necessary equipment and supplies using the same criteria described in WAC 388-554-500(5).

(12) ((~~MAA~~)) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies that are ((~~not covered or are~~)) in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(13) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies, that are listed as noncovered in this chapter, under the provision of WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 01-01-009, filed 12/6/00, effective 1/6/01)

WAC 388-556-0500 Medical care services under state-administered cash programs. Medical care services (MCS) are state-administered medical care services provided to a client receiving cash benefits under the general assistance-unemployable (GA-U) program or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program. For a client eligible for MCS:

(1) The department of social and health services (DSHS) covers only the medically necessary services within the ((~~notated~~)) applicable program limitations listed in the MCS column under WAC ((~~388-529-0200~~)) 388-501-0060.

(2) DSHS does not cover medical services received outside the state of Washington unless the medical services are provided in a border area listed under WAC 388-501-0175.

AMENDATORY SECTION (Amending WSR 03-02-079, filed 12/30/02, effective 1/30/03)

WAC 388-800-0045 What services are offered by ADATSA? If you qualify for the ADATSA program you may be eligible for:

(1) Alcohol/drug treatment services and support described under WAC-388-800-0080.

(2) Shelter services as described under WAC 388-800-0130.

(3) Medical care services as described under WAC 388-556-0500 ((~~and 388-529-0200~~)), WAC 388-501-0060, and WAC 388-501-0065.